SUBSTANCE ABUSE INDIVIDUALIZED RECOVERY TREATMENT PLAN

Consumer Name: ______________________ Date of Admission: ____________

Diagnosis _____________________ Estimated Length of Stay _________________

Level of Care I - ____ hours/week Continued Stay (circle one): 60 days 10 hours

Staff responsible:____

Problem Statement (in client's own words):

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Goal/Outcome I:____

____

Consumer strengths and how they will be used to meet this goal: ________________

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Objective#____: ____

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Dimension: _____ Service: ______ Frequency: ______ Target Date: ______

Objective #____: ____

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Dimension:______ Service:______ Frequency:______ Target Date: ______

Objective #____: ____

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Dimension:______ Service:______ Frequency:______ Target Date:______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:_______ Target Date:_______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:_______ Target Date:_______

Problem Statement (in client's own words):

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Goal/Outcome II: ____

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Consumer strengths and how they will be used to meet this goal: __________________

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Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date: _______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date: _______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date:_______

Case Management Plan

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Goal/Outcome I:____

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Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date:_______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date:_______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date:_______

Goal/Outcome II: ____

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Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date:_______

Objective #____: ____

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Dimension:_______ Service:_______ Frequency:________ Target Date:______

REFERENCE SHEET – SUBSTANCE ABUSE RECOVERY TREATMENT PLANS

01 – **Individual Counseling**

02 – **Group Counseling** – Consumers and their significant others process issues related to their treatment

06 – **Didactic Group** – Educate consumers and their significant others on a specific treatment-related topic

07 – **Recreation**

08 – **Telephonic Counseling**

12 – **Medication Monitoring** – Physician only

21 – **Case Management – Consumer Engagement and Retention**

22 – **Case Management – Intra-Agency Staffing**

23 – **Case Management – Case Coordination** – with other providers

41 – **Family or Significant Other** – meeting with a family member or significant other to discuss consumer's care

42 – **Other (Employer, Friend, Minister, etc.)** – meeting to discuss consumer's care

CASE MANAGEMENT SERVICES: As part of my treatment planning; I will make reports to probation or other appropriate services client involved in and client will complete all recommendations.

Client has been oriented to services in the following manner: Informed of emergency phone number 911, appointment cancellation policy, group times, hours of operation, and agency phone number.

INDIVIDUALIZED RECOVERY TREATMENT PLAN DEVELOPMENT

I acknowledge by my signature that the process for development of my Individualized Recovery Treatment Plan and the contents of my treatment plan have been explained to me. I further acknowledge that I participated in the development of my plan, have been offered a copy of the plan, have had a chance to ask questions, have had my questions answered, I understand my recovery treatment plan and agree to actively participate in implementing my plan.

I have ___accepted a copy of my recovery treatment plan.

Consumer Signature:______________________________ Date:___________________

_____(Staff Initials) I acknowledge by my signature that I have explained the treatment planning process and contents of the treatment plan to the consumer and/or guardian.

Medical Director:__________________________________ Date:___________________

Responsible Staff:______________________________ Date:___________________

Program Director:________________________________ Date:___________________

Other Signatures/Date:____

*****I have complete TB/HIV/STD Education

____

Client Signature/Date Therapist Signature/Date